FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032011

Facility Name: Norridge Hlthcr & Rehab Centre

Address: 7001 W. Cullom Ave. (Number) Norridge (City) 60656 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

IDPA ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-02 to 31-Dec-02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 28-March-2003 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	315	TOTALS	315	114,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38,570	22,205	9,535	70,310	8
9	SNF/PED					9
10	ICF	19,403	3,540		22,943	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,973	25,745	9,535	93,253	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.11%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Jan-1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 8,345

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	434,582	61,850	24,240	520,672		520,672		520,672			1
2	Food Purchase		503,909		503,909	(22,358)	481,551	(1,306)	480,245			2
3	Housekeeping	351,227	86,171		437,398		437,398		437,398			3
4	Laundry	166,505	69,875		236,380		236,380		236,380			4
5	Heat and Other Utilities			251,314	251,314		251,314		251,314			5
6	Maintenance	80,961	64,685	74,217	219,863		219,863	3,581	223,444			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,033,275	786,490	349,771	2,169,536	(22,358)	2,147,178	2,275	2,149,453			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	4,052,682	311,027	26,616	4,390,325		4,390,325		4,390,325			10
10a	Therapy		2,383	17,510	19,893		19,893		19,893			10a
11	Activities	147,716	26,686	863	175,265		175,265		175,265			11
12	Social Services	155,321	2,350	4,381	162,052		162,052		162,052			12
13	Nurse Aide Training		544		544		544		544			13
14	Program Transportation											14
15	Other (specify):* Dental Services			945	945		945		945			15
16	**TOTAL Health Care and Programs**	4,355,719	342,990	80,315	4,779,024		4,779,024		4,779,024			16
	C. General Administration											
17	Administrative	111,183		378,000	489,183		489,183	(157,151)	332,032			17
18	Directors Fees											18
19	Professional Services			36,488	36,488		36,488	20,501	56,989			19
20	Dues, Fees, Subscriptions & Promotions			30,652	30,652		30,652	47,199	77,851			20
21	Clerical & General Office Expenses	323,864	47,913	188,627	560,404		560,404	7,377	567,781			21
22	Employee Benefits & Payroll Taxes			920,277	920,277	22,358	942,635	43,833	986,468			22
23	Inservice Training & Education			5,780	5,780		5,780		5,780			23
24	Travel and Seminar			3,174	3,174		3,174	12,282	15,456			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,001	102,001		102,001		102,001			26
27	Other (specify):*							22,369	22,369			27
28	**TOTAL General Administration**	435,047	47,913	1,664,999	2,147,959	22,358	2,170,317	(3,590)	2,166,727			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,824,041	1,177,393	2,095,085	9,096,519		9,096,519	(1,315)	9,095,204			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre #0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			132,847	132,847		132,847	545,782	678,629			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,498	5,498		5,498	1,506,658	1,512,156			32
33	Real Estate Taxes			429,929	429,929		429,929		429,929			33
34	Rent-Facility & Grounds			2,484,000	2,484,000		2,484,000	(2,484,000)				34
35	Rent-Equipment & Vehicles			5,473	5,473		5,473		5,473			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,057,747	3,057,747		3,057,747	(431,560)	2,626,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,862	201,772	383,634		383,634		383,634			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,463	172,463		172,463		172,463			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		181,862	374,235	556,097		556,097		556,097			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,824,041	1,359,255	5,527,067	12,710,363		12,710,363	(432,875)	12,277,488			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,325	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,306)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(672)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,294)	21		24
25	Fund Raising, Advertising and Promotional	(11,032)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,400)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,682)	20		28
29	Other-Attach Schedule Deferred Maintenance	1,408	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,653)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(297,222)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (297,222)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (432,875)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Norridge Hlthcr & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-02

Ending: 31-Dec-02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Allowance	$ 1,408	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,408		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,306)	0	0	0	0	0	0	0	0	0	0	(1,306)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,408	2,173	0	0	0	0	0	0	0	0	0	3,581	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	102	2,173	0	0	0	0	0	0	0	0	0	2,275	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(157,151)	0	0	0	0	0	0	0	0	0	(157,151)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,501	0	0	0	0	0	0	0	0	0	20,501	19
20	Fees, Subscriptions & Promotions	(15,386)	62,585	0	0	0	0	0	0	0	0	0	47,199	20
21	Clerical & General Office Expenses	(142,694)	150,131	0	0	0	0	0	0	0	0	0	7,437	21
22	Employee Benefits & Payroll Taxes	0	43,833	0	0	0	0	0	0	0	0	0	43,833	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,282	0	0	0	0	0	0	0	0	0	12,282	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	22,369	0	0	0	0	0	0	0	0	0	22,369	27
28	**TOTAL General Administration**	(158,080)	154,550	0	0	0	0	0	0	0	0	0	(3,530)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(157,978)	156,723	0	0	0	0	0	0	0	0	0	(1,255)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-02 **Ending:** 31-Dec-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	22,325	3,072	0	0	0	0	0	0	0	0	0	25,397	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,110	0	0	0	0	0	0	0	0	0	11,110	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	22,325	14,182	0	0	0	0	0	0	0	0	0	36,507	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,653)	170,905	0	0	0	0	0	0	0	0	0	35,252	45

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 215,861	$ 215,861	1
2	V		27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	7,833	7,833	2
3	V		17	Management Fee Income	378,000	Lancaster, Ltd.	100.00%		(378,000)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	20,501	20,501	4
5	V		21	Clerical Expenses		Lancaster, Ltd.	100.00%	150,131	150,131	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	43,833	43,833	6
7	V		24	Education and Seminars		Lancaster, Ltd.	100.00%	12,282	12,282	7
8	V		17	Administrative Consultant		Lancaster, Ltd.	100.00%	4,988	4,988	8
9	V		20	Fees and Marketing		Lancaster, Ltd.	100.00%	62,585	62,585	9
10	V		32	Interest		Lancaster, Ltd.	100.00%	11,110	11,110	10
11	V		30	Depreciation		Lancaster, Ltd.	100.00%	3,072	3,072	11
12	V		6	Maintenance		Lancaster, Ltd.	100.00%	2,173	2,173	12
13	V		27	Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	14,536	14,536	13
14	Total				$ 378,000			$ 548,905	$ * 170,905	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Laurence Zung	Executive Officer	Administrative	40.00%	see attached	24	50.00%	Lancaster	$ 176,150	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	6.00%	see attached	9	19.00%	Lancaster	23,232	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	6.00%	see attached	9	19.00%	Lancaster	16,479	17-7	3
4	Sandra Bernett	Administrator	Administrator	5.00%	see attached	40	100.00%	Lancaster	0	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 215,861		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)478.3699
Fax Number: (773)478.1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 352,300	$ 352,300	24	$ 176,150	1
2	27	Laurence Zung	Hours Worked	48	7	10,482	0	24	5,241	2
3	17	Christopher Vicere	Hours Worked	48	7	123,902	123,902	9	23,232	3
4	27	Christopher Vicere	Hours Worked	48	7	7,171	0	9	1,345	4
5	17	Cheryl Morris	Hours Worked	48	7	87,889	87,889	9	16,479	5
6	27	Cheryl Morris	Hours Worked	48	7	6,648	0	9	1,247	6
7										7
8										8
9	19	Professional Services	Management Fees	1,611,600	7	87,404	0	378,000	20,501	9
10	21	Clerical Expenses	Management Fees	1,611,600	7	35,722	0	378,000	8,379	10
11	22	Employee Benefits	Management Fees	1,611,600	7	186,880	0	378,000	43,833	11
12	24	Education and Seminars	Management Fees	1,611,600	7	11,327	0	378,000	2,657	12
13	17	Administrative Consultant	Management Fees	1,611,600	7	21,265	0	378,000	4,988	13
14	20	Marketing	Management Fees	1,611,600	7	251,556	174,958	378,000	59,002	14
15	32	Interest	Management Fees	1,611,600	7	11,616	0	378,000	2,725	15
16	30	Depreciation	Management Fees	1,611,600	7	13,099	0	378,000	3,072	16
17	20	Licenses and Fees	Management Fees	1,611,600	7	15,277	0	378,000	3,583	17
18	6	Maintenance	Management Fees	1,611,600	7	9,263	0	378,000	2,173	18
19	24	Travel	Management Fees	1,611,600	7	41,037	0	378,000	9,625	19
20	21	Salaries - Clerical	Management Fees	1,611,600	7	604,357	604,357	378,000	141,752	20
21	27	Payroll Taxes-Clerical	Management Fees	1,611,600	7	61,975	0	378,000	14,536	21
22										22
23	32	Direct Interest							8,385	23
24										24
25	TOTALS					$ 1,939,170	$ 1,343,406		$ 548,905	25

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lincoln National Bank		X		$69,917.94	3/10/93	$ 4,875,000	$			$ 9,431	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American Nat'l (Bank One)		X	Working Capital							2,725	6
7	Harston Investments		X								1,500,000	7
8												8
9	TOTAL Facility Related				$69,917.94		$ 4,875,000	$			$ 1,512,156	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,875,000	$			$ 1,512,156	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-02 **Ending:** 31-Dec-02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	453,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	437,929	2
3. Under or (over) accrual (line 2 minus line 1).	$	(15,071)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	445,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	429,929	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997	406,247	8
1998	441,463	9
1999	446,465	10
2000	447,232	11
2001	437,929	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Hlthcr & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-18-318-005-0000	Long-Term Healthcare	$ 109,325.04	$ 109,325.04
2.	13-18-318-006-0000	Long-Term Healthcare	$ 109,325.04	$ 109,325.04
3.	13-18-318-007-0000	Long-Term Healthcare	$ 109,953.59	$ 109,953.59
4.	13-18-318-008-0000	Long-Term Healthcare	$ 109,325.04	$ 109,325.04
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 437,928.71	$ 437,928.71

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nsg. Care Facility		1986	$ 650,000	1
2	Sect 754 basis adj.			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986	1976	$ 9,204,000	$ 478,608	30	$ 478,608	$	$ 5,777,044	4
5					1,315,965	41,777	30	36,789	(4,988)	445,160	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,399	20	8,011	6,612	32,861	9
10	Various			1988	3,940	126	20	706	580	3,392	10
11	Various			1988	28,574	1,547	20	3,337	1,790	26,607	11
12	Various			1989	1,297	43	20	189	146	956	12
13	Various			1990	3,827	123	20	529	406	2,704	13
14	Various			1990	28,644	909	20	3,764	2,855	17,474	14
15	Various			1991	72,916	2,320	20	8,171	5,851	40,893	15
16	Various			1992	36,639	1,306	20	3,263	1,957	19,399	16
17	Various			1993	72,513	1,909	20	6,463	4,554	33,200	17
18	Various			1994	116,353	3,017	20	7,056	4,039	46,411	18
19	Various			1995	95,409	2,443	20	4,775	2,332	35,547	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	244	20	470	226	3,066	20
21	Tuckpointing			1999	28,900	741	20	1,887	1,146	5,518	21
22	Architect Fee 1st Floor			2001	15,052	386	20	386		724	22
23	Construction 1st Floor			2001	166,662	4,274	20	4,274		8,013	23
24	Construction Library			2001	12,461	319	20	319		599	24
25	Design Fee-1st Floor			2001	5,130	131	20	131		247	25
26	Sprinklers-1st Floor			2001	4,531	116	20	116		218	26
27	Demolition-1st Floor			2001	5,533	142	20	142		266	27
28	Wooden Doors (2)			2001	1,134	30	20	30		55	28
29	Construction Work			2001	4,207	107	20	107		139	29
30	Smoking Shelter			2002	3,251	80	20	325	245	325	30
31	Auto Front Door			2002	2,074	29	20	121	92	121	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,281,977	$ 542,126		$ 569,969	$ 27,843	$ 6,500,939	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 560,069	$ 80,225	$ 75,554	$ (4,671)	10	$ 807,823	71
72	Current Year Purchases	163,831	30,219	32,616	2,397	10	32,616	72
73	Fully Depreciated Assets	476,788	3,735	491	(3,244)		476,788	73
74								74
75	TOTALS	$ 1,200,688	$ 114,179	$ 108,661	$ (5,518)		$ 1,317,227	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,259,453	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 656,305	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 678,630	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,325	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,818,166	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,473 Description: Minolta Copier @ $456.07/month
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 88,872	$		$ 88,872	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,870			6,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			106,030			106,030	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				118,885		118,885	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Inhalation Therapy Other (specify): MedSup/Sp Bed Rent	39-2					62,977		62,977	13
14	TOTAL			$		$ 201,772	$ 181,862		$ 383,634	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 65,022	$ 71,666	1
2	Cash-Patient Deposits	83,641	83,641	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,019,738	3,019,738	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,628	72,628	6
7	Other Prepaid Expenses	1,566	1,566	7
8	Accounts Receivable (owners or related parties)	643,616	1,125,012	8
9	Other(specify): Employee Advances	47,092	47,092	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,933,303	$ 4,421,343	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	762,006	762,006	15
16	Equipment, at Historical Cost	1,200,694	1,643,829	16
17	Accumulated Depreciation (book methods)	(1,111,887)	(9,804,397)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(162,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	100,000	100,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 950,813	$ 3,998,191	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,884,116	$ 8,419,534	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,621	$ 226,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,173	40,173	28
29	Short-Term Notes Payable	153,299		29
30	Accrued Salaries Payable	534,916	534,916	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,479	16,479	31
32	Accrued Real Estate Taxes(Sch.IX-B)	445,000	445,000	32
33	Accrued Interest Payable	51,502	51,502	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Employee 401(k) Contributiuons	6,294	6,294	36
37	**Wage Assignments	1,776	1,776	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,476,060	$ 1,322,761	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,476,060	$ 16,322,761	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,408,056	$ (7,903,227)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,884,116	$ 8,419,534	48

***(See instructions.)**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (9,199,835)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (9,199,835)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,089,754	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(676,714)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ***Capital Contributions**	883,568	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,296,608	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (7,903,227)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,656,484	1
2	Discounts and Allowances for all Levels	(1,482,752)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,173,732	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	765,832	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 765,832	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	32,924	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	182,063	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,665	19
20	Radiology and X-Ray	14,560	20
21	Other Medical Services	127,139	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 386,351	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	75	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 75	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending commissions	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,331,990	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,169,536	31
32	Health Care	4,779,024	32
33	General Administration	2,147,959	33
	B. Capital Expense		
34	Ownership	3,057,747	34
	C. Ancillary Expense		
35	Special Cost Centers	383,634	35
36	Provider Participation Fee	172,463	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,710,363	40
41	**Income before Income Taxes (line 30 minus line 40)****	621,627	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 621,627	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** ***Cash Basis Taxpayer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,789	2,286	$ 89,713	$ 39.24	1
2	Assistant Director of Nursing	1,893	2,231	75,452	33.82	2
3	Registered Nurses	41,866	43,428	1,381,340	31.81	3
4	Licensed Practical Nurses	34,880	37,371	861,972	23.07	4
5	Nurse Aides & Orderlies	147,980	156,496	1,366,813	8.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,933	2,255	43,533	19.31	9
10	Activity Assistants	10,716	11,745	104,183	8.87	10
11	Social Service Workers	10,799	12,063	155,321	12.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,888	45,142	434,582	9.63	15
16	Dishwashers					16
17	Maintenance Workers	5,322	5,775	80,961	14.02	17
18	Housekeepers	38,220	41,203	351,227	8.52	18
19	Laundry	19,906	22,048	166,505	7.55	19
20	Administrator	1,941	2,134	77,063	36.11	20
21	Assistant Administrator	1,605	1,646	34,120	20.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,784	23,139	323,864	14.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	15,072	21,470	277,392	12.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	397,594	430,432	$ 5,824,041 *	$ 13.53	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	808	$ 24,240	1-3	35
36	Medical Director	750	30,000	9-3	36
37	Medical Records Consultant	116	4,187	10-3	37
38	Nurse Consultant	320	9,600	10-3	38
39	Pharmacist Consultant	504	7,560	10-3	39
40	Physical Therapy Consultant	500	17,510	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	863	11-3	44
45	Social Service Consultant	115	4,381	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,131	$ 98,341		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	102	$ 3,996	10-3	50
51	Licensed Practical Nurses	74	1,273	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	176	$ 5,269		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bernett	Administrator	N/A	$ 77,063
Julie Olds	Asst.Administrator	N/A	18,171
Safet Keljalic-effective 9/4/02	Asst.Administrator	N/A	15,950
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,183

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd.	$ 378,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 378,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Richard Peelo & Associates	Accounting	$ 2,250
Frost, Ruttenberg & Rothblatt	Accounting	1,185
Panarese & Panarese	Legal	1,475
Personnel Planners, Inc.	Payroll Tax Consultant	1,725
Purchasing Plus	Purchasing Consultant	6,500
Medi.Com	Data Processing	1,235
Health Data Systems, Inc.	Data Processing	15,031
Power Software	Data Processing	3,370
Computer MD, Inc.	Data Processing	2,123
Advanced Telecommunication	Data Processing	60
Accu-Med Services, Inc.	Data Processing	820
Msci	Data Processing	714
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 36,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,379
Unemployment Compensation Insurance	41,215
FICA Taxes	437,655
Employee Health Insurance	305,091
Employee Meals	22,358
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	2,011
Retirement Plan Contributions	54,064
Misc. Employee Benefits	12,862
Lancaster Allocation	43,833
TOTAL (agree to Schedule V, line 22, col.8)	$ 986,468

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	7,184
Health Care Worker Background Check	
(Indicate # of checks performed 44)	528
Promotional Advertising	14,714
Contributions	672
Dues & Subscriptions	1,853
Licenses & Fees	5,201
Related Parties Allocation	62,585
Less Contributions	(672)
Less: Public Relations Expense	( )
Non-allowable advertising	(11,032)
Yellow page advertising	(3,682)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 77,851

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	465
Seminar Expense	2,709
Lancaster Allocation	12,282
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,456

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	May-96	$ 10,664	3	$ 1,777	$	$	$	$	$	$	$	$
2	Painting & Decorating	Sep-96	13,428	3	2,238								
3	Painting & Decorating	Nov-96	5,922	3	987								
4	Painting & Decorating	Jul-97	3,238	3	1,079	540							
5	Painting & Decorating	Nov-97	2,814	3	938	469							
6	Painting & Decorating	Mar-98	4,660	3	1,553	1,553	777						
7	Painting & Decorating	May-98	3,318	3	1,106	1,106	553						
8	Painting & Decorating	Aug-99	2,834	3	472	945	945	472					
9	Painting & Decorating	Nov-99	1,966	3	328	655	655	328					
10	Painting & Decorating	Mar-2000	585	3	97	195	195	98					
11	Painting & Decorating	Oct-2000	266	3	45	88	88	45					
12	Painting & Decorating	Nov-2000	50	3	8	17	17	8					
13	Painting & Decorating	Dec-2000	180	3	30	60	60	30					
14	Painting & Decorating	Aug-2001	1,281	3			214	427	427	213			
15													
16													
17													
18													
19													
20	TOTALS		$ 51,206		$ 10,658	$ 5,628	$ 3,504	$ 1,408	$ 427	$ 213	$	$	$

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-02 **Ending:** 31-Dec-02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,121** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **172,463**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,358** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.